Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH LLC
5445 LA SIERRA DRIVE 204
DALLAS TX 75231

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-09-8713-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was processed incorrectly. The claim was denied and per EOB entitlement to benefits, not finally adjudicated. The treatment that was provided is part of her compensable injury to her low back that she sustained on 04/14/07. Also, the service provided was preauthorized, **#848472**."

Amount in Dispute: $230.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier accepts a compensable injury in the form of a lumbar strain only. Carrier disputes any and all other body parts and/or conditions other than a lumbar strain. This includes, but is not limited to, any and all psychological conditions, mental trauma, stress, anxiety and/or sleep disorders."

Response Submitted by: Flahive Ogden & Latson, fax # 512-692-6670

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2008 July 28, 2008	CPT code 90806	$230.12	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 23, 2008
   - W11-Entitlement to benefits. Not finally adjudicated. Payment is being withheld pending an investigation of the reasonable and necessity of the treatment.

   Explanation of benefits dated August 18, 2009
   - 12-Extent of injury. Not finally adjudicated. We are in receipt of your bill for services. Payment is being withheld pending further investigation of compensability/treatment. Please contact the claim handler for additional info.

   Explanation of benefits dated August 25, 2008
   - Reimbursement for procedure was withheld due to previous submission on (06/25/08).

   Explanation of benefits dated November 13, 2008
   - 12-Extent of injury not finally adjudicated. Reimbursement withheld – charge unrelated to compensable injury.

   Explanation of benefits dated January 7, 2009
   - 12-Extent of injury not finally adjudicated. Reimbursement withheld – charge unrelated to compensable injury.

   Explanation of benefits dated January 16, 2009
   - W4-No addl reimbursement allowed after review of appeal/reconsideration. Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. Service rendered requires peauth.

Issues

1. Does a compensability issue exist in this dispute?

Findings

1. The December 3, 2008 Benefit Review Agreement found that "The compensable injury of 04/14/07 includes lumbar disc disease, but does not include psychological conditions, mental trauma, stress, sleep disorder, anxiety, depression or major depressive disorder."

   The requestor submitted Individual Psychotherapy Notes that indicate that the treatment was for the primary diagnosis: "296.21 Major Depressive Disorder, single, moderate, secondary to the work injury." This diagnosis was found to be non-compensable at the December 3, 2008 Benefit Review Agreement.

   28 Texas Administrative Code §133.307(a) indicates that "In resolving disputes over the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the commission is to adjudicate the payment, given the relevant statutory provisions and commission rules." Because the psychotherapy treatment was for treatment that was found to be non-compensable, the Division lacks jurisdiction to review these services; therefore, this decision will not consider these services any further.

   The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		5/9/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.